

CHILD CARE OF THE BERKSHIRES FAMILY CHILD CARE SYSTEM
CHILD'S DEVELOPMENTAL INFORMATION

CHILD & FAMILY INFORMATION

Child's Name: _____

Child's Date of Birth: _____

Mother/guardian: _____

Father/guardian: _____

Primary Language: _____

Primary Language: _____

Optional : Highest grade completed _____

Optional : Highest grade completed _____

With whom has the child lived for most of the past year? _____
Who are the other members of your household? _____
Names & relationship: _____

Does your child visit another parent on a regular basis? Yes _____ No _____ Please explain: _____

CHILD'S BIRTH HISTORY

Were there any significant problems during pregnancy and/or during delivery? Yes _____ No _____
If yes, please explain: _____

Was your child more than 3 weeks premature? Yes _____ No _____ If yes, how many weeks? _____

Baby's birth weight _____.

At the time of birth, did the baby have any treatments for (check): jaundice _____ rash _____ breathing difficulties _____
convulsions _____

If yes, please explain _____

Did the baby stay in the hospital longer than the mother? Yes _____ No _____
If yes, please explain _____

CHILD'S HEALTH

Allergies, asthma, hay fever, insect bites, food reaction, medicine:

Please describe and indicate reaction if/when exposed:

Are any medications given frequently? Yes _____ No _____ If yes, please describe: _____

Indicate Birth marks/scars on your child:

Do you have concerns about your child's ability to hear? Yes _____ No _____

Frequent ear infections? Yes _____ No _____

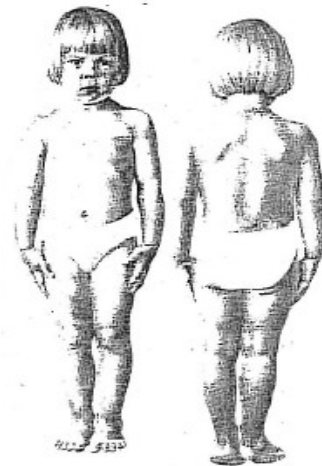
Do you have concerns about your child's vision? Yes _____ No _____

Has your child ever had trouble walking, climbing, reaching, or holding on to things? Yes _____ No _____ If yes, please explain: _____

Has your child ever had any significant illnesses, injuries or hospitalizations? Yes _____ No _____ If yes, please explain: _____

Please explain: _____

Any special physical conditions, disabilities? Yes _____ No _____



CHILD'S DEVELOPMENT AND INFORMATION ON DAILY HABITS

Please provide information for your infant/toddler (marked *) as appropriate to the age of your child.

- * Can your baby sit up unassisted? Yes _____ No _____ Do you remember at what month? _____
- * Can your baby crawl? Yes _____ No _____ Started at approximately what month? _____
- * Can your baby pull up? Yes _____ No _____
- * Can your baby walk with help? Yes _____ No _____
- * Can your baby walk alone? Yes _____ No _____
- * Does your child have a fussy time? Yes _____ No _____ If yes, when: _____
- * Does your child use a pacifier? Yes _____ No _____ If yes, when: _____

Can your child talk? Yes _____ No _____ Does your child use sign language? Yes _____ No _____

Can your child use words to ask for things? Yes _____ No _____

Does your child speak clearly? Yes _____ No _____

Can your child get dressed without assistance? Yes _____ No _____

Can your child climb stairs? Yes _____ No _____

Does your child trip easily? Yes _____ No _____

Did you have concerns about your child's development when they were younger? Yes _____ No _____

If yes, please describe: _____

Has your child ever been involved with any Early Intervention Program/PDC/Public School Program? Yes _____ No _____

If yes, were any special services offered? Yes _____ No _____

Please describe: _____

Does your child focus on an activity? Yes _____ No _____ or get distracted easily? Yes _____ No _____

Does your child have a favorite (circle): toy _____ blanket _____ comfy _____ describe/other _____

Can your child follow simple directions? Yes _____ No _____

Child's eating habits:

* Is your baby using formula? Yes _____ No _____

* Has your baby settled into a regular feeding schedule?

If yes, please explain (times, ounces at each feeding, etc): _____

* Is your baby eating solid foods? Yes _____ No _____

* How is your child fed (circle): In your lap _____ High chair _____ Other _____

* Is your child beginning to eat with hands? Yes _____ No _____ With a spoon? Yes _____ No _____

Can your child feed themselves unassisted? Yes _____ No _____

Does your child have a special diet and/or eating problems: Yes _____ No _____

Please describe: _____

Does your child set with the family and eat at regular mealtimes Yes _____ No _____

Or does your child prefer to eat small portions/snacks throughout the day? Yes _____ No _____

Your child prefers to eat (circle): at the table _____ In front of TV _____ In bedroom _____ Other _____

Is your child open to new foods? Yes _____ No _____

Does your child tend to eat (check): slowly _____ fast _____ average _____ other _____

Bathroom needs:

*Does your child get diaper rashes easily? Yes _____ No _____

*Has toilet training been attempted? Yes _____ No _____

Has your child started to use the bathroom? Yes _____ No _____

If yes, does your child use: potty chair special child seat regular seat

How does your child indicate bathroom needs (include special words): _____

Is this the stage where accidents still happen? Yes _____ No _____

Has your child had frequent bouts of diarrhea? Yes _____ No _____

Have there been periods of constipation? Yes _____ No _____

Social relationships

Has your child had experience playing with other children? Yes _____ No _____

Has your child had experience being left with other adults? Yes _____ No _____

Has your child been in child care before? Yes _____ No _____ If yes, Where and when: _____

If your child becomes upset when you leave, what is the best way to comfort them?

How would you describe your child (circle): Friendly Aggressive Shy Quiet Curious Sensitive Happy

Is your child frightened by (circle): Loud noises Animals Rough children Storms Darkness Anything else?

Does your child cry easily? Yes ___ No

Does your child have temper tantrums? Yes ___ No ___

What is the best way to sooth your child? _____

What method of behavior management/discipline used at home (time out, redirection, etc)?

Does your child have a TV, VCR or DVD player in their bedroom? Yes ___ No ___

Does your child use a computer? Yes ___ No ___ How often? _____

Approximately how many hours per day does your child spend watching TV or movies? _____

Sleeping

Do you have any concerns about your child's sleeping pattern, for example, going to bed with difficulty or waking often during the night? Yes _____ No _____ If yes, please explain:

Where does your child sleep (circle): Bed Crib with sibling with parent

Does your child take anything to bed with them (bottle, pacifier, comfy)? Yes _____ No _____

If yes, please describe _____

How does your child behave when they are getting tired?

What time does your child usually go to bed at night? _____

What time does your child usually get up in the morning? _____

If your child still takes naps, at about what time? _____ For how long? _____

Is there anything else we should know about your child?

Parent/guardian's signature _____ Date _____